Reimbursement for Medicaid Family Health Clinic Program

I. Authority. This amendment is established pursuant to the authorization granted to the Department of Social Services, Division of Medical Services.

II. Qualification. For a clinic to qualify for participation in the Medicaid Family Health Clinic (FHC) program, the clinic must meet all of the following criteria:

(A) The clinic must have qualified for reimbursement as a Department of Social Services owned and operated Primary and Prenatal Care Clinic on June 30, 1994;

(B) The clinic must have applied for a not-for-profit status exempt from Federal income tax under the provisions 501(C) of the Internal Revenue Code as of June 1, 1995;

(C) Provide services to county residents with incomes below 200% of the federal poverty level on a sliding fee scale basis, regardless of ability to pay for the services;

(D) Provide on-site, or have firm financial arrangements, for diagnostic laboratory and radiologic services, and pharmacy services; and

(E) Provide social services to patients to assist with meeting psychosocial, behavioral, and environmental needs, through linkages with community resources and collaborative activities regarding public health issues with the local health departments.

III. General Principles.

(A) The Missouri Medical Assistance (Medicaid) program shall reimburse Family Health Clinic (FHC) providers based on the reasonable cost of FHC-covered services related to the care of Medicaid recipients (within program limitations) less any copayment or other third party liability amounts which may be due from Medicaid recipients effective for services on and after February 2, 1994.

(B) Reasonable costs shall be determined by the Division of Medical Services based on desk review of the applicable cost reports and shall be subject to adjustment based on field audit. Reasonable costs shall not exceed the Medicare cost principles set forth in 42 CFR Part 413.

(C) Reasonable costs shall be apportioned to the Medicaid program based on a ratio of covered charges for beneficiaries to total charges. Charges mean the regular rate for various services which are established uniformly for Medicaid recipients and other patients.

IV. Definitions.

(A) Desk review. The Division of Medical Services' review of a provider's cost report without on-site audit.

(B) Division. Unless otherwise designated, division refers to the Division of Medical Services, the division of the Department of Social Services charged with administration of Missouri's Medical Assistance (Medicaid) program.

(C) Facility fiscal year. A facility's twelve (12)-month fiscal reporting period.

(D) Generally accepted accounting principles (GAAP). Accounting conventions, rules and procedures necessary to describe accepted accounting practice at a particular time promulgated by the authoritative body establishing those principles.

(E) Provider or facility. A Family Health Clinic with a valid Medicaid participation agreement in effect on or after February 2, 1994 with the Department of Social Services for the purpose of providing FHC services to Title XIX-eligible recipients.

V. Administrative Actions.

(A) Annual Cost Report.

1. Each FHC shall complete a Medicaid cost report for the FHC's twelve (12)-month fiscal period.

2. Each FHC is required to complete and submit to the Division of Medical Services an Annual Cost Report, including all worksheets, attachments, schedules and requests for additional information from the division. The cost report shall be submitted on forms provided by the division for that purpose.

3. All cost reports shall be completed in accordance with the requirements of this rule and the cost report instructions. Financial reporting shall adhere to GAAP except as otherwise specifically indicated in this regulation.

4. The cost report shall be submitted within three (3) calendar months after the close of the reporting period. A single extension, not to exceed thirty (30) days, may be granted upon the request of the FHC and the approval of the Missouri Division of Medical Services. The request must be received in writing by the division prior to the ninetieth day of the three (3) calendar-month period after the close of the reporting period.

5. In a change of ownership, the cost report for the closing period must be submitted within forty-five (45) calendar days of the effective date of the change of ownership, unless the change in ownership coincides with the seller's fiscal year end, in which case the cost report must be submitted within three (3) calendar months after the close of the reporting period. No extensions in the submitting of cost reports shall be granted when a change in ownership has occurred.

6. Cost reports shall be submitted and certified by an officer or administrator of the provider. Failure to file a cost report within the prescribed period, except as expressly extended in writing by the state agency, may result in the imposition of sanctions.

7. Authenticated copies of agreements and other significant documents related to the provider's operation and provision of care to Medicaid recipients must be attached to the cost report at the time of filing unless current and accurate copies have already been filed with the division. Material which must be submitted includes, but is not limited to, the following:

A. Audit, review or compilation statement prepared by an independent accountant, including disclosure statements and management letter;

B. Contracts or agreements involving the purchase of facilities or equipment during the last five (5) years if requested by the division, the department or its agents;

C. Contracts or agreements with owners or related parties;

D. Contracts with consultants;

E. Schedule detailing all grants, gifts and income from endowments, including: amounts, restrictions, and use;

F. Documentation of expenditures, by line item, made under all restricted and unrestricted grants, gifts or endowments;

G. Statement verifying the restrictions as specified by the donor, prior to donation, for all restricted grants;

H. Leases and/or rental agreements related to the activities of the provider;

I. Management contracts;

J. Provider of service contracts; and

K. Working trial balance actually used to prepare cost report with line number tracing notations or similar identifications.

8. Under no circumstances will the division accept amended cost reports for final settlement determination or adjustment after the date of the division's notification of the final settlement amount.

(B) Records.

1. Maintenance and availability of records.

A. A provider must keep records in accordance with GAAP and maintain sufficient internal control and documentation to satisfy audit requirements and other requirements of this regulation, including reasonable requests by the division or its authorized agent for additional information.

B. Adequate documentation for all line items on the cost report shall be maintained by a provider. Upon request, all original documentation and records must be made available for review by the division or its authorized agent at the same site at which the services were provided. Copies of documentation and records shall be submitted to the division or its authorized agent upon request.

C. Records of related organizations, as defined by 42 CFR 413.17, must be available upon demand.

D. The Missouri Division of Medical Services shall retain all uniform cost reports submitted for a period of at least three (3) years following the date of submission of the reports and will maintain those reports pursuant to the record keeping requirements of 42 CFR 413.20.

E. Each facility shall retain all financial information, data and records relating to the operation and reimbursement of the facility for a period of not less than five (5) years.

2. Adequacy of records.

A. The division may suspend reimbursement or reduce payments to the appropriate fee schedule amounts if it determines that the FHC does not maintain records that provide an adequate basis to determine payments under Medicaid.

B. The suspension or reduction continues until the FHC demonstrates to the division's satisfaction that it does, and will continue to, maintain adequate records.

(C) Audits.

1. Any cost report submitted may be subject to field audit by the division or its authorized agent.

2. A provider shall have available at the field audit location one (1) or more knowledgeable persons authorized by the provider and capable of explaining the provider's accounting and control system and cost report preparation, including all attachments and allocations.

3. If a provider maintains any records or documentation at a location which is not the same as the site where services were provided, the provider shall transfer the records to the same facility at which the services were provided, or the provider must reimburse the division or its authorized agent for reasonable travel costs necessary to perform any part of the field audit in any off-site location, if the location is acceptable to the division.

(D) Change in Provider Status. The next payment due the provider after the division has received the notification of the termination of participation in the Medicaid program or change of ownership may be held by the division until the cost report is filed. Upon receipt of a cost report prepared in accordance with this rule, the payments that were withheld will be released.

VI. Nonallowable Costs. Cost not reasonably related to FHC services shall not be included in a provider's costs. Nonallowable cost areas include, but are not limited to, the following:

(A) Bad debts, charity and courtesy allowances;

(B) Return on equity capital;

(C) Capital cost increases due solely to changes in ownership;

(D) Amortization on intangible assets, such as goodwill, leasehold rights, covenants, but excluding organizational costs;

(E) Attorney fees related to litigation involving state, local or federal governmental entities and attorney's fees which are not related to the provision of FHC services, such as litigation related to disputes between or among owners, operators or administrators;

(F) Central office or pooled costs not attributable to the efficient and economical operation of the facility;

(G) Costs such as legal fees, accounting and administration costs, travel costs and the costs of feasibility studies which are attributable to the negotiation or settlement of the sale or purchase of any capital asset by acquisition of merger for which any payment has been previously made under the program;

(H) Late charges and penalties;

(I) Finder's fees;

(J) Fund-raising expenses;

(K) Interest expense on intangible assets;

(L) Religious items or supplies or services of a primarily religious nature performed by priests, rabbis, ministers or other similar types of professionals. Costs associated with portions of the physical plant used primarily for religious functions are also nonallowable;

(M) Research costs;

(N) Salaries, wages or fees paid to nonworking officers, employees or consultants; and

(O) Costs of services performed in a satellite clinic, which does not have a valid Medicaid participation agreement with the Department of Social Services for the purpose of providing FHC services to Title XIX-eligible recipients.

VII. Interim Payments. Effective for services provided on or after February 2, 1994, FHC services, unless otherwise limited by regulation, shall be reimbursed on an interim basis by Medicaid at ninety-five percent (95%) of usual and customary charges as billed by the provider for covered FHC services. Interim payments shall be reduced by copayments and other third party liabilities.

VIII. Reconciliation.

(A) The state agency shall perform an annual desk review of the Medicaid cost reports for each FHC's fiscal year and shall make indicated adjustments of additional payment or recoupment, in order that the FHC's net reimbursement shall be in amounts representing one hundred percent (100%) of reasonable costs.

(B) Notice of program reimbursement. The division shall send written notice to the FHC:

1. Underpayments. If the total reimbursement due the FHC exceeds the interim payments made for the reporting period, the division makes a lump-sum payment to the FHC to bring total interim payments into agreement with total reimbursement due the FHC.

2. Overpayments. If the total interim payments made to a FHC for the reporting period exceed the total reimbursement due the FHC for the period, the division arranges with the FHC for repayment through a lump-sum refund, or, if that poses a hardship for the FHC, through offset against subsequent interim payments or a combination of offset and refund.

(C) The annual desk review will be subject to adjustment based on the results of a field audit which may be conducted by the division or its contracted agents.

IX. Sanctions.

(A) The division may impose sanctions against a provider in accordance with 13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services or any other sanction authorized by state or federal law or regulation.

(B) Overpayments due the Medicaid program from a provider shall be recovered by the division in accordance with 13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services.

X. Appeals. Providers may seek hearing before the Administrative Hearing Commission of final decisions of the director, Department of Social Services or the Division of Medical Services.

XI. Payment Assurance.

(A) The state will pay each FHC, which furnishes the services in accordance with the requirements of the state plan, the amount determined for services furnished by the FHC according to the standards and methods set forth in the regulations implementing the FHC Reimbursement Program.

(B) FHC services provided for those recipients having available Medicare benefits shall be reimbursed by Medicaid to the extent of the coinsurance and deductible as imposed under Title XVIII.

(C) Where third-party payment is involved, Medicaid will be the payor of last resort.

(D) Regardless of changes of ownership, management, control, leasehold interests by whatever form for any FHC previously certified for participation in the Medicaid program, the department will continue to make all the Title XIX payments directly to the entity with the FHC's current provider number and hold the entity with the current provider number responsible for all Medicaid liabilities.

XII. Payment in Full. Participation in the Medicaid program shall be limited to providers who accept as payment in full, for covered services rendered to Medicaid recipients, the amount paid in accordance with these regulations and applicable copayments.